Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CARL CANNON MD
1441 WOODSTEAD SUITE 300
WOODLANDS TX 77380

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-13-0001-01

MFDR Date Received
SEPTEMBER 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Filed claim in timely fashion. Ins sent us notice on 7/15/10 that they received our claim, but needed attach ments which we had. Faxed 7/7/10 and received confirmation. We have appealed numerous times it is still being denied based on appeal 9/1/11 also."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ""The Office respectfully requests the Division deem this dispute not eligible for review as it has been determined that the provider did not submit the medical fee dispute in accordance with Rule §133.307(c)(1)(A). "

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2010	CPT code 99080-73	$15.00	$0.00
	CPT Code 20610	$140.00	$0.00
	HCPCS Code J1030	$10.00	$0.00
TOTAL		$165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, effective May 31, 2012, sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16-Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate.
- 73-TWCC73 report form.
- The required documentation was not submitted with the bill. Please attach and resubmit complete bill to carrier with original timely filing deadline for further review.
- 29-The time limit for filing has expired.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- A request for reconsideration is to be submitted no later than 11 months from the date of service per rule 133.250(b).

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is June 22, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 4, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/6/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.